April 30, 1997

Honorable James B. King
Director
U.S. Office of Personnel Management
Washington, D.C. 20415

Dear Mr. King:

I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period October 1, 1996 to March 31, 1997. This report describes our office's activities during the past six-month reporting period.

Should you have any questions about the report or any other matter of concern, please do not hesitate to call upon me for assistance.

Sincerely,

Patrick E. McFarland
Inspector General

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Foreword

In several recent semiannual reports, I have focused attention on the work we have undertaken to counter health care fraud affecting the Federal Employees Health Benefits Program (FEHBP). In particular, I have called attention to our efforts to see legislation enacted that would provide our Office of Inspector General (OIG) with the necessary tools to become more effective on behalf of safeguarding the FEHBP and the vested interest of its direct participants (employees and annuitants and their family members) and that of the American taxpayer, whose tax dollars help fund this program.

Such an example is P.L. 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our OIG is supporting an amendment to HIPAA to include the FEHBP as a full participant under the provisions of this Act. We believe it is critical that the FEHBP, as the third largest federally funded health insurance program in the United States, be on an equal footing with other federal health care programs in combating health care fraud. A more extensive discussion of this issue can be found in our Statutory and Regulatory Review section on pages 2 and 3 of this report.

In addition, throughout my tenure as Inspector General at the Office of Personnel Management (OPM), I have vigorously advocated changes to the FEHBP administrative sanctions program authorized under a provision of the 1988 FEHBP Amendments Act. The present statute is unworkable and requires a cumbersome hearing process, and that is why I have strongly sup-ported new legislation to correct these deficiencies. I am in the process of initiating new legis-lation modeled on the Department of Health and Human Services sanctions program that I believe will be an efficient and effective mechanism for eliminating fraudulent providers from the FEHBP. A similar proposal was introduced and passed by the House during the last Congress, but time restraints prevented its consideration by the Senate prior to adjournment.

At this time, I wish to express my appreciation to Director James B. King and members of Congress, who have shown both support and encouragement for our mission and our continuing efforts to eliminate waste, fraud, and abuse within the OPM-based programs we oversee. We pledge to use all the resources at our disposal to maintain the vigilance necessary to fulfill our statutory obligations.

Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds $49,455,069

Recoveries Through Investigative Actions $19,154,685

Management Commitments to Recover Funds 43,705,891

Note: ***These amounts include recoveries jointly reported by our Office of Audits and Office of Investigations referenced on pages 10, 13, 21, 22, 31, and 34 of this report.***

ACCOMPLISHMENTS:

Audit Reports Issued 15

Investigative Cases Closed 29

Cases Accepted for Prosecution 16

Indictments 11

Convictions 9

Hotline Contacts and Complaint Activity 1564

Health Care Provider Debarments and Suspensions 597

Evaluation and Inspections Reports Issued 1

Statutory and Regulatory Review

As is required under section 4 (a)(2) of the Inspector General Act of 1978 (IG Act), as amended, our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General and Office of Personnel Management programs and operations. Specifically, we perform this activity to evaluate their potential for encouraging economy and efficiency and preventing fraud, waste and mismanagement. We also monitor legal issues that have a broad effect on the Inspector General community.

During this reporting period, we examined numerous legislative proposals affecting OPM programs and took action on a legislative mandate for IGs to audit administratively uncontrollable overtime, a form of pay primarily affecting law enforcement agencies. We also submitted testimony regarding health care fraud legislation. Some of these activities are highlighted below.

Legislative Review

Administratively Uncontrollable Overtime (AUO) Audit

Section 650 of the Treasury, Postal Service, and General Government Appropriations Act, 1997, contained within P.L. 104-208, the Omnibus Consolidated Appropriations Act, requires that each Inspector General conduct an audit of the use of AUO pay at his or her agency if that agency pays annual premium pay for administratively uncontrollable overtime work or to report if none had been paid. The law requires that within 45 days of enactment each agency paying AUO will examine the policies, extent, costs, and other relevant aspects of the use of AUO and determine whether the eligibility criteria of each agency and payment of AUO complies with federal statute.

To address ambiguities in the law concerning the IG mandate, several IGs met with representatives from Senator John McCain's staff, the sponsor of the AUO amendment. Under the agreement reached with Senator McCain, the scope of the audits would cover only fiscal year 1996, and the audit reports would be completed, as required by law, within four months of enactment of the legislation. All reports were to be submitted to OPM, the Senate Committee on Governmental Affairs and the House Committee on Government Reform and Oversight. OPM thereafter would be required to issue revised guidance to agencies on proper implementation of AUO.

To assist OPM's Office of Compensation Policy in issuing revised guidance, our OIG served as liaison in collecting the AUO audit reports from Inspectors General by contacting all agencies that did not submit reports. To date, all agencies except one have submitted reports.

OIG Assists Agency in Collecting AUO Audit Reports

IG Submits Testimony on Health Care Records

On February 14, 1997, our office provided a statement for the record to the National Committee on Vital and Health Statistics, Subcommittee on Privacy and Confidentiality, to address the issue of privacy and confidentiality of medical records. This administrative committee was established under the Health Insurance Portability and Accountability Act, P.L. 104-191, to assist the Secretary of the Department of Health and Human Services in promulgating regulations governing privacy and access to medical records.

Our testimony addressed legislative proposals under consideration that would place tighter restrictions on access to medical records by law enforcement entities. For example, H.R. 52, the Fair Health Information Practices Act of 1997, adopts a probable cause and notice requirement for subpoenas that we believe would place an unnecessary and insurmountable burden on our operations. With a limited staff, adding additional hurdles beyond the present standard of relevancy to the process for accessing medical information would increase the likelihood of litigation at an early investigative stage. This would considerably limit our ability to effectively and efficiently investigate, prosecute and deter health care fraud. This office relies heavily on OIG subpoenas. Therefore, implementation of additional due process procedures would severely diminish the utility of this indispensable tool.

Section 119 of H.R. 52, covering law enforcement, contains an exception that would allow a "health oversight agency" to receive medical information from a "health information trustee" without adhering to the more restrictive compulsory process requirements. It is, however, unclear whether an Office of Inspector General falls within the definition of a health oversight agency.

For this reason, we recommended that the committee strongly consider specifically including OIGs within the definition of a health oversight agency as part of any legislative proposal governing access to individual medical records. This exception would preserve the existing legal standards that are presently in place for investigators, including Office of Inspector General special agents.

IG Provides Testimony on Medical Records Confidentiality & Access

Testimony Provided to Senate on Amending HIPAA

Our office provided a statement for the record to the Senate Committee on Labor and Human Resources for an oversight hearing conducted on February 11, 1997, on implementation of the Health Insurance Portability and Accountability Act referenced in the preceding article.

As discussed in the last semiannual report, the Federal Employees Health Benefits Program was omitted from certain fraud provisions in the legislation. We informed the committee that, if left uncorrected, this omission will continue to have a detrimental effect on the FEHBP.

When Congress added major fraud-fighting tools for federal health care programs, it excluded the FEHBP, the third largest health care expenditure program in the United States. By limiting our agency's ability to stop wrongdoers from diverting precious health care dollars from deserving patients, this erroneous exclusion of the FEHBP from section 204 (f)(1) of the Act ultimately will have a negative impact on all taxpayers and result in higher premium costs for all federal employees.

We also mentioned in our last semiannual report that had my office and the responsible OPM program offices been consulted on this matter, we would have vigorously opposed removal of the FEHBP from the Act's provisions. We advised the committee that if we are to continue as a credible participant in the war against health care fraud, we need the additional fraud-fighting weapons made available to other agencies by HIPAA.

IG Urges Inclusion of FEHBP in Health Care Fraud Act

Audit Activities

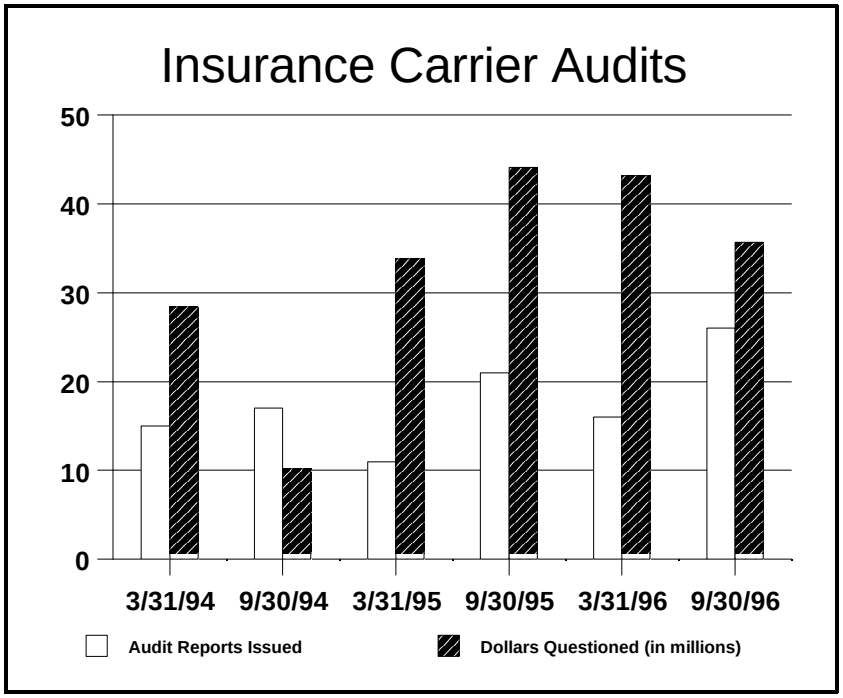
Health and Life Insurance Carrier Audits

The Office of Personnel Management contracts with private sector firms to underwrite and provide health and life insurance benefits to federal employees, annuitants, and their dependents and survivors through the Federal Employees Health Benefits Program and the Federal Employees' Group Life Insurance Program.

Our audit universe contains approximately 545 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations, as well as two life insurance carriers, all of which share in annual premium payments in excess of $16.5 billion. Our Office of Inspector General is responsible for auditing their operations.

During the current reporting period, we issued 13 final reports on organizations participating in the FEHBP, all of which contain recommendations for monetary adjustment in the aggregate amount of $49.5 million due the FEHBP. A complete listing of these reports is provided in Appendix III on pages 33-34 of this report.

We feel it is important to illustrate the dollar significance resulting from our audits of FEHBP carriers and what this means to the FEHBP trust fund. For instance, during the six previous semiannual reporting periods, the OIG issued 106 reports and questioned
$195.5 million in inappropriate FEHBP charges as the graph below illustrates.



The sections that immediately follow explain the differences among the types of FEHBP carriers and provide audit summaries of significant final reports we issued during the past six months.

Community-Rated Plans

Within the community-rated, comprehensive medical plans, also known as health maintenance organizations (HMOs), we have approximately 450 rating areas that we audit. A community-rated carrier generally sets the subscription rates for benefits on the basis of an average revenue requirement for each member. Under current statutes for HMOs, subscription rates can vary from group to group as the result of adjustments for factors such as the age and sex distribution of a group's enrollees (community rating by class) or its projected utilization of benefits (adjusted community rating). However, once a rate is set, it may not be adjusted to actual costs incurred or actual utilization. The inability to adjust to actual costs or utilization distinguishes community-rated plans from experience-rated HMOs, indemnity, or service benefit plans.

Prior to 1991, all community-rated carriers were required to submit a certificate of community rating, certifying that the rates offered to OPM were in fact the community rates being offered to all groups, adjusted for benefit differences. OIG's audits of community- rated plans were designed to verify that the community rates certified to OPM were being consistently charged to **all** groups. If an audit disclosed that the carrier had offered some groups rates lower than the community rates, then a condition of defective community rating (DCR) was deemed to exist. OPM regulations and FEHBP contract clauses provided that OPM was entitled to a downward rate adjustment. This adjustment reflected the fact that, as a result of accepting community-rating principles, OPM had given up the right to negotiate rates on a competitive basis.

In 1991, OPM revised its regulations to require that subscription rates charged to the FEHBP be equivalent to the rates charged those subscriber groups closest in size to the FEHBP and whose respective contracts contain similar benefits. These similarly sized subscriber groups are called SSSGs. Under these regulations, each carrier must certify that the FEHBP is being offered equivalent SSSG rates by submitting to OPM a certificate of accurate pricing. These rates are determined by the FEHBP-participating carrier, which has the responsibility of selecting the two groups that qualify as SSSGs. During an audit, should our auditors determine that equivalent rates were not applied to the FEHBP or that the appropriate SSSGs were not selected, then a condition of defective pricing (DP) exists. The FEHBP is entitled to a downward rate adjustment to compensate for any overcharges resulting from DP.

During this reporting period, we issued six audit reports on community-rated plans. The following summaries of two HMO audits issued during the period illustrate a number of problems encountered in applying and enforcing community-rating

principles within the
FEHBP.

Share Health Plan of Illinois, Inc. in Itasca, Illinois

Report No. FP-00-94-022

January 30, 1997

Share Health Plan of Illinois, Inc., in Itasca, Illinois, is a wholly owned subsidiary of UHC Management Company, Inc. (UHC), an HMO management corporation providing services to the plan under the terms of a management agreement. UHC, in turn, is owned by United HealthCare Corporation, based in Minneapolis, Minnesota, where our audit was conducted. This was our first audit of Share Health since it entered the FEHBP beginning January 1, 1985. Our audit covered contract years 1989 through 1993.

Share Health provides health care services throughout the Chicago metropolitan area. Its total membership at the end of the last year of our audit (1993) was approximately 84,000, with the FEHBP constituting its largest group at 11 percent. During contract years 1989 through 1993, the FEHBP paid premiums to the plan totaling approximately $46.3 million.

We examined premium rates for compliance with the plan's certificates of community rating and accurate pricing filed with our agency and determined that there were violations resulting in overcharges to the FEHBP totaling $6,188,651 for the five-year period covered by our audit. In accordance with the FEHBP contract and regulations governing community-rated carriers, the FEHBP also is entitled to recover lost investment income on DCR and DP overcharges. In this instance, we determined that the FEHBP was due an additional $1,351,563 from 1989 through 1995, along with unspecified additional amounts for the period January 1, 1996, until the funds are actually returned to the FEHBP. We also noted that the plan charged the FEHBP a special loading (rider) for "inpatient nervous and mental days" in all the years under review and that this loading was improperly developed by the plan, resulting in FEHBP overcharges of $181,873. As a result of our findings, we determined the total amount due the FEHBP at $7,722,087.

Questioned Costs to FEHBP Total $7,722,087

Premium Rates and Loadings

Our examination of premium rates in 1989 showed that the plan offered discounted rates to several large groups that year. The FEHBP's 1989 rates were developed using a traditional rating methodology, while a different methodology was employed for commercial groups (community-rating-by-class). Inasmuch as the plan was unable to provide demographic support for any of the age/sex factors it used in developing the commercial groups' rates, we concluded that the FEHBP was entitled to a rate adjustment equal to the lowest rate (largest discount) offered to any of the plan's

groups during the same contract period. Share Health, while acknowledging our finding, did not agree with the recommended remedy. Similarly, in 1990, the plan offered discounted rates to several large groups that were not extended to the FEHBP. By federal regulation, the FEHBP is entitled to a market price adjustment for that year equaling the highest discount provided to a similarly sized group. We applied a market price adjustment factor to the FEHBP rates to calculate the amount of that adjustment.

In 1991 and 1992, Share Health was in violation of its certificate of accurate pricing in each instance by selecting the wrong SSSG to establish FEHBP's rates. The SSSGs in question received, respectively, a 12.6 percent and 13.9 percent discount below the market price rate charged to the FEHBP for those years. And again, in 1993, we determined that the FEHBP was not rated in a manner consistent with the plan's SSSGs. In this instance, the FEHBP was charged a rate that was 16.6 percent higher than the plan's established market price rate. While disagreeing with the specific amounts we recommended for recovery, Share Health acknowledged in a July 13, 1994 letter to OPM that it had overcharged the FEHBP $4,434,315 for contract years 1990 through 1993 and that it has begun to repay monies owed for those years.

As previously mentioned, we learned that the plan incorrectly calculated a special loading for inpatient nervous and mental days covering all the years under review, resulting in a $181,873 overcharge to the FEHBP. Share Health agrees that the loading was incorrectly developed, but the plan has taken the position that we have overstated the adjustment due the FEHBP. The plan has based its position on its interpretation of the FEHBP contract as well as the Federal Employees Health Benefits Acquisition Regulations.

While we did not agree with Share Health's position regarding any of our recommendations for reimbursement to the FEHBP, we did note that any of the amounts already recouped by OPM from Share Health should be taken into consideration when the plan makes final settlement.

Rating System

We reviewed the plan's rating of subscriber groups and met with Share Health officials in this regard. As a result, we determined that the plan does not have adequate internal controls in place to assure that its rating system is in compliance with applicable FEHBP laws and regulations or that the rates charged to the FEHBP represent community or market price rates. In this regard, we found that the plan did not have written policies and procedures describing their rating system.

Consequently, we included in our recommendations that the OPM contracting officer direct the plan to establish written policies and procedures that would assure compliance with the laws and regulations previously alluded to. We also recommended that the plan be required to maintain all pertinent records for five years, including actual enrollment reports and claims experience information, evidentiary demographic information used for rate setting, and written guidelines for each rating year, along with a clear description of each department's or activity's responsibility and authority as each relates to the rating process.

Auditors Make Recommendations to Improve Premium Rating System

FHP, Inc.
in Fountain Valley, California

Report No. 66-00-92-059

March 12, 1997

Our audit of the FEHBP operations at FHP, Inc., in Fountain Valley, California, covered contract years 1987 through 1991. FHP provides member health benefits in Arizona, California, Guam, New Mexico, and Utah. We examined the plan's federal rate submissions and related documents along with rating documents and billings to other groups FHP serviced during those contract years to determine if the plan had offered either community rates or market price rates to the FEHBP in accordance with its contract and OPM regulations. We also looked at loadings (riders) to the FEHBP contract for those years to see if they were reasonable and equitable and reviewed enrollment statistics to verify their accuracy.

Our audit of the Arizona region covered contract years 1987 through 1991, while the audit for the other four regions encompassed contract years 1988 through 1991. We found that the plan provided discounted rates to numerous groups from 1987 through 1991. Since the plan did not give the FEHBP similar discounts, we determined that the FEHBP was entitled to retroactive rate adjustments totaling $17,753,593. This amount also included overcharges by the plan relating to its children's loadings, outpatient copay undercharges, and industry factors (adjustments a member group receives based on the specific industry environment of its subscribers). It should be noted that, in a previous audit of FHP, completed in 1987, we also cited the plan for improper rate adjustments that produced overcharges to the FEHBP.

Questioned Costs to FEHBP Total $17,753,593

Our audit revealed that defective community rating or pricing issues were prevalent across all FHP regions. The plan's use of unsupported demographic assumptions in developing rates for many non-FEHBP groups consistently produced discounted rates, and thus preferential treatment, for those groups. The pervasiveness of these practices is best illustrated in the following summary of findings by region.

Arizona: In its 1987 through 1989 rate submissions to OPM, the plan reported that it used either a traditional rating or a community-rating-by-class (CRC) rating methodology for establishing rates for its member groups in Arizona. Although the plan had established book rates (standard community rates), several groups were afforded rates below the book rate. In reviewing 1990 and 1991 rate submissions, we concluded no retroactive rate adjustments were warranted.

California: For the audit period 1988 through 1991, our review of the plan's rating methodology for groups in the California region showed that FHP used unsupported

demographics to rate many of its groups. Using assumed data rather than actual, the plan was able to lower rates for some groups. We took particular exception to this use of arbitrary demographic statistics to legitimatize reduced rates, a practice indicative of DCR and DP.

Guam: Our review indicated that several groups were afforded discounted rates through FHP's use of unsupported favorable demographics in its rate calculations. We also found instances whereby the plan reduced a particular group's calculated CRC rates for no apparent reason.

New Mexico: We found many instances where selected groups received discounted premium rates from FHP. In addition, we noted a report issued by the New Mexico Department of Insurance for the period January 1, 1988 through June 30, 1990, that cited the plan for charging lower than state-filed community rates to many of its groups.

Utah: For the period 1988 through 1991, FHP departed from its established procedures of using actual demographics in favor of demographics predicated on the assumption that a group's average contract size would decrease as a result of the open season campaign. The use of these predictions resulted in lower rates for the groups involved. In the case of the region's largest group, FHP used an "area adjustment factor" as a means to lower the group's rates.

The plan did not agree with the merit of any of our findings. Our review of FHP's response to the draft report, as well as an in-depth analysis of our audit work papers, prompted us to refer certain audit issues, including DCR and DP issues, to our Office of Investigations and later to the Department of Justice (DOJ) for further scrutiny. In October of 1996, the U.S. Attorney's office for the District of Columbia reached a negotiated settlement with FHP in the amount of $12 million. (See also Appendix I on page 31 as well as pages 21-22 of the Investigative Activities section of this report.)

FHP, Inc. Agrees to $12 Million Settlement

Experience-Rated Plans

In addition to community-rated plans, the FEHBP offers a variety of experience-rated plans, including the Government-wide Service Benefit Plan, plans sponsored by employee organizations, and comprehensive medical plans (experience-rated HMOs). An experience rate is a rate that reflects a given group's projected paid claims, administrative expenses, and retentions. Each carrier maintains separate accounts for its federal contract, and future premiums are adjusted to reflect the federal enrollees' actual past use of benefits.

Audits of these plans generally focus on the allowability of contract charges and the recovery of appropriate credits, the effectiveness of carriers' claims adjudication systems, and the adequacy of internal controls to ensure proper contract charges and benefit payments.

Government-Wide Service Benefit Plan

This plan is administered by the Blue Cross and Blue Shield (BCBS) Association on behalf of its member plans. The association delegates authority to participating local Blue Cross and Blue Shield plans throughout the United States to underwrite and process the health benefits claims of its federal subscribers in the Service Benefit Plan. For administrative purposes, the association has established a Federal Employees' Program (FEP) Director's Office in Washington, D.C., that provides centralized management for the Service Benefit Plan, including a central claims control center known as the FEP Operations Center. This center, among other things, verifies subscribers eligibility, approves or disapproves the reimbursement of local plan payments of FEHBP claims (using computerized system edits), and maintains both a history file of all FEHBP claims and an accounting of all program funds.

The BCBS federal employee program currently consists of approximately 60 audit sites throughout the United States. Approximately 40 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans nationwide.

During this reporting period, we issued five BCBS reports. The following two audit summaries describe the major findings from those reports, along with the questioned costs associated with those findings.

Blue Cross and Blue Shield of Utah in Salt Lake City, Utah

Report No. 10-66-91-028

January 29, 1997

Our audit of Blue Cross and Blue Shield of Utah (BCBS of Utah) covered administrative expenses charged to the FEHBP for 1986 through 1990 and health benefits payments made between January 1, 1990 and May 31, 1991. We conducted this audit at BCBS of Utah's headquarters in Salt Lake City, Utah. For the last full contract year we audited (1990), the plan administered benefits for about 18,200 FEHBP subscribers in the state of Utah, which constituted four percent of the plan's total enrollees that year.

Specifically, our examination included the plan's BCBS FEHBP accounting statements for the years audited; a review of the plan's claims processing systems; and a study of its policies, procedures, and allocation methods for supplementary payments, refunds and uncashed checks. We also made an evaluation of the plan's compliance with laws and regulations governing the FEHBP. As a result of the audit, we questioned costs for inappropriate charges to the FEHBP totaling

$1,578,669. Additionally, we noted that the plan's fraud control activities were weak and ineffective, thus increasing the likelihood that FEHBP resources could be exposed to fraud. We recommended that the OPM contracting officer require the plan to implement stronger fraud detection procedures as well as develop and update mission statements for all cost centers, the latter recommendation having been proposed by the BCBS Association itself several years earlier.

Listed below by audit category are several of the major findings resulting from this audit.

Questioned Costs to FEHBP Total $1,578,669

Health Benefits

During the 17-month period covered in our review of health benefit payments, BCBS of Utah paid 1.1 million claims in the amount of $56.7 million. To test BCBS of Utah's compliance with FEHBP health benefit provisions, we examined a random sample of claims and reviewed selected claims for potential duplicate payments, noncoordinated benefit claims, and other noncovered benefits. We also examined refund recoveries from FEHBP subscribers to see how promptly the plan was crediting the FEHBP for these recoveries. As a result of our review, we identified $26,074 in erroneous and unnecessary charges to the FEHBP and determined that no refund recoveries received by the plan had been credited to the FEHBP at the time of our audit.

Administrative Expenses

When our auditors examined administrative expenses charged to the FEHBP by BCBS of Utah, they determined that there were several instances of unreasonable or improper expenses charged to the FEHBP that resulted in questioned costs of $1,552,595. The following are two examples of findings relating to administrative costs affecting the FEHBP.

Gain on sale of home office building: Our review showed that the FEHBP was not credited with its proportional share of the gain on the sale of the plan's home office building as required by federal regulation. In December 1986, the plan sold its home office under a sale and leaseback arrangement and repurchased the property in December 1987. The repurchase of the property triggered a gain on BCBS of Utah's own books. However, the proportion of this gain to which the FEHBP was entitled was not allocated. We noted that the plan realized a gain of $3,252,933 on the transaction, of which $1,567,623 represented depreciation that had been charged to all lines of business by the plan. Taking into account this depreciation, we calculated FEHBP's share of the gain at $144,544. While the BCBS Association, acting on behalf of the plan, initially took issue with our position regarding the accounting of

the transactions, the matter has been subsequently resolved to the satisfaction of all parties, and the amount questioned has been recovered by the FEHBP.

Administrative cost adjustments: From 1987 through 1990, the plan significantly increased the FEHBP's share of administrative costs by making unsupported, manual out-of-system adjustments. Our review of these out-of-system adjustments showed that plan personnel routinely increased FEHBP costs without adequate documentation or justification. We reviewed time sheets for employees in many of the adjusted cost centers and found that they did not support the additional costs allocated to the FEHBP. After issuance of our draft report, our auditors first referred this issue to our OIG investigators, who were able to identify additional questionable adjustments made by the plan's employees. We then referred our findings to the U.S. Attorney's office for review.

Negotiated Settlement

The U.S. Attorney's office for the District of Columbia negotiated a settlement with BCBS of Utah in the amount of $2.2 million, although the plan continued to disagree with the merits of some of our audit findings. As a result of the settlement agreement $1,665,000 was returned to the FEHBP and $535,000 for damages was paid to the U.S. Treasury. (See also Appendix I on page 31 as well as page 22 of the Investigative Activities section of this report.)

U.S. Attorney's Office Reaches $2.2 Million Settlement with Carrier

Blue Cross and Blue Shield of Texas in Dallas, Texas

Report No. 10-29-94-043

January 22, 1997

Blue Cross and Blue Shield of Texas (BCBS of Texas) has its headquarters in Dallas, Texas. Our most recent audit covered contract years 1988 through 1993 for administrative expenses and premium taxes and the contract period January 1, 1991 through October 31, 1993, for health benefits payments. The plan administered benefits for about 99,000 FEHBP subscribers in Texas during 1993, which represented 5.6 percent of the plan's total enrollees for that year. Also in 1993, BCBS of Texas paid over 1.5 million FEHBP claims, representing approximately $265 million in health benefits payments.

We did not audit health benefits payments for 1987 through 1990 nor administrative expenses and premium tax charges for 1987 because of the expiration of the records retention period in each instance. A review of our previous audit of BCBS of Texas, covering contract years 1982 through 1986, revealed that the plan has continued its noncompliance in the areas of duplicate payments and coordination of benefits

relating to Medicare.

As a result of this most recent audit, our auditors identified questioned costs for inappropriate charges to the FEHBP totaling $7,017,223, including $1,539,473 for lost investment income to the FEHBP trust fund. Listed below by audit category are several of the major findings resulting from our current audit.

Questioned Costs to FEHBP Total $7,017,223

Health Benefits

To test BCBS of Texas's compliance with FEHBP health benefit provisions, we examined claim samples consisting of 2,291 claim lines, representing $4,348,116 in health benefits payments made from January 1, 1991 through October 31, 1993. Among the costs we questioned were health benefits charges relating to improper coordination of benefits with Medicare ($662,941), duplicate payments ($172,809), interplan duplicate payments originally paid by another BCBS plan ($3,117), noncovered private room charges ($66,742), and failure to reject claims of terminated dependents ($1,546). In addition, we noted problems with the timely crediting of health benefits payment refunds to the FEHBP as prescribed in its FEHBP contract, resulting in a loss of interest income amounting to $1,454,095.

Inappropriate health benefits charges to the FEHBP for the period totaled $2,361,250. We have recommended that OPM's contracting officer direct the plan to return this amount to the FEHBP trust fund, along with implementing controls and procedures to avoid these and other problems described in our audit report. The BCBS Association has agreed to improve internal controls and provide additional training to BCBS employees to correct some of the deficiencies and other claim-related errors we noted in our audit. However, it continues to disagree with some of our findings and recommendations, while others are still under review, particularly those pertaining to the issue of coordination of benefits.

Administrative Expenses

We also examined administrative expenses charged to the FEHBP by BCBS of Texas to determine whether they were actual, necessary and reasonable expenses incurred in accordance with the contract and applicable federal regulations. As a result, we questioned $766,809 in inappropriate charges. The following are examples of findings we identified in this area.

Excess leasing costs: During the contract years we reviewed (1988-1993), BCBS of Texas allocated leasing costs in excess of cost of ownership on its home office building. Inasmuch as federal regulations do not permit rental costs under a sale and leaseback arrangement to exceed normal cost of ownership, we calculated that the FEHBP was charged $746,658 for excessive leasing costs. We have recommended

to the contracting officer that this amount be disallowed. The association disagrees with this finding.

Disallowed marketing-related costs: In contract years 1990 and 1991, the plan allocated marketing sales conference expenses to a cost center that resulted in a charge to the FEHBP for unallowable selling expenses in the amount of $10,123. The reason this is unallowable is that we consider this type of expense in the category of public relations and advertising costs. In addition, between 1989 and 1991, the plan charged the FEHBP $16,700 for marketing costs related to the "Your Healthy Best" (YHB) program. In an agreement reached in 1994 with the BCBS Association, it was determined that OPM would disallow 60 percent of the YHB costs charged to the FEHBP from 1985 though 1990, and base costs incurred from 1991 though 1994 on FEHBP enrollment statistics. As a result, we determined that $10,028 of the $16,700 charged to the FEHBP from 1989 through 1991 was unallowable. The association agreed with both issues and stated that the funds would be returned to the FEHBP. We recommended that the contracting officer ensure that these amounts had been returned.

Cash Management

Cash management: The last major finding addressed in this audit concerns the plan's management of FEHBP funds from the letter of credit (LOC) account. The federal government pays its premiums to the plan through an LOC account managed by the Blue Cross and Blue Shield Association. Through its management of the LOC, the BCBS Association also has a responsibility in this matter. As we have mentioned in prior reports, plans should not be receiving funds from the LOC until their payments to health providers and/or subscribers have cleared their respective banks. We discovered that BCBS of Texas was receiving FEHBP funds on average almost eight days before such payments had cleared.

As a result of the BCBS Association's reimbursement procedure at that time, the plan maintained excess FEHBP funds on hand. Furthermore, we determined that the plan had commingled FEHBP funds with other income-producing accounts and had not credited to the FEHBP interest earned on those excess funds as required by its FEHBP contract.

Based on our review of this plan's cash management practices, we calculated that the federal government lost $2,349,691 in investment income for contract years 1988 through 1993. We have recommended not only that the plan credit that amount to the FEHBP but that the contracting officer direct the BCBS Association to adopt immediately the "checks-presented" method of executing drawdowns under the LOC program.

Employee Organization Plans

These plans also fall in the category of experience-rated and may operate or sponsor participating health benefits programs. Employee organization plans operate on an indemnity and fee-for-service basis. Members are free to obtain treatment through facilities or providers of their choice for which claims are submitted to the carrier for adjudication and payment.

During the reporting period, we issued two employee organization plan audit reports. One of these is summarized in the following narrative.

Union Labor Life Insurance Company as Underwriter/Administrator for the AFGE Benefit Plan in Washington, D.C.

Report No. 30-04-94-040

February 14, 1997

Union Labor Life Insurance Company (ULLICO), headquartered in Washington, D.C., was the subject of an audit we conducted that covered its underwriter and contract administrator activities on behalf of the American Federation of Government Employees (AFGE) for contract years 1988 through 1990. We also reviewed the AFGE Health Plan contract close-out period that ended May 31, 1993, in connection with the termination of its FEHBP contract on December 31, 1990. The reason for the close-out period is that when an FEHBP contract is terminated, the affected plan is generally given a two-year period to close out all business activities related to the contract. Such was the case in this instance.

Our audit was designed to determine whether or not costs charged to the FEHBP were in accordance with the terms of the contract and to assess the degree to which ULLICO's operations were in compliance with the laws and regulations governing the FEHBP. Our audit did not include a review of health benefits payments made on behalf of the underwritten plan.

The audit covered administrative expenses, credits, refunds and rebates as well as premium taxes charged to the FEHBP for the period stated above. AFGE subcontracted underwriting and contract administration responsibilities, including claims processing, to ULLICO for which ULLICO was reimbursed $10,665,348 for the years in question. Our last audit of ULLICO as an underwriter for this plan covered contract years 1984 and

1985.

Our examination of ULLICO specifically included a review of the policies, procedures, and allocation methods for refunds, uncashed checks, and provider reimbursements. We also examined ULLICO's policies and procedures related to OPM's letter of credit system for 1990 and 1991 to determine the appropriateness of ULLICO's LOC activities in connection with the AFGE plan.

While ULLICO disagreed with many of our findings and in particular the methodology we used to ascertain some of the questioned costs, we identified $1,771,712 in questioned costs, including $1,559,819 in unallowable and unsupported administrative expenses that ULLICO charged to the FEHBP. Examples of some of these expenses include excessive rent for space in the ULLICO building, unsupported case management and cost containment fees, excessive leasing charges relating to the sale and leaseback of equipment and furniture, unallowable market and public relations expenses, as well as unsupported legal expenses. We determined that the FEHBP was also entitled to $211,893 in lost investment income resulting from these questioned costs associated with AFGE's contract with OPM.

Auditors Question $1,771,712 in Inappropriate FEHBP Charges

OTHER EXTERNAL AUDITS

As requested by Office of Personnel Management procurement officials, our OIG conducts pre- and post-award contract audits relating to the acquisition of goods and services by agency program offices. Our office also conducts audits of the local organizations of the Combined Federal Campaign (CFC), the solely authorized fund-raising drive conducted in federal installations throughout the world .

Pre-Award and Post-Award Contracts

These contract audits are performed to ensure that costs anticipated to be, or claimed to have been, incurred under the terms of these contracts are accurate and in accordance with provisions of the Federal Acquisition Regulation. The results of these audits provide OPM procurement officials with the best information available for use in contract negotiations and oversight. In the case of post-award contracts, for instance, the verification of actual costs and performance charges may be useful in negotiating contract modifications as these relate to cost-savings and efficiency.

We issued one report covering a pre-award contract, as requested by the OPM procurement office. This report recommends a downward adjustment in the labor rate charged to OPM, which would result in a savings (funds put to a better use) in one year of approximately $85,800. For additional information, refer to Appendix II, page 32, and Appendix IV, page 35.

Combined Federal Campaign

On March 18, 1961, Executive Order 10927 transferred to the chairman of the U.S. Civil Service Commission (the precursor of OPM) the responsibility to arrange for national voluntary health and welfare agencies to solicit funds from federal employees and members
of the armed services at their place of employment. Since then, there have been two more executive orders, one public law (P.L. 100-202), and the issuance of federal regulations (5 CFR Part 950) detailing the eligibility of national and local organizations and charities as participants, the role of local combined federal campaigns, and the oversight responsibilities of the Office of Personnel Management with respect to the Combined Federal Campaign.

One of our agency's oversight responsibilities is auditing the local CFCs, a role our OIG has been performing since 1991. These audits focus on the eligibility of local charities to participate in the campaigns, local campaign compliance with CFC regulations, and the testing of the various local campaigns' financial records. CFC audits will not ordinarily identify savings to the government, because the funds involved are charitable donations made by federal employees.

Since 1961, the CFC has netted over $3.2 billion in charitable contributions. Our most recent statistical data available comes from the 1995 CFC. Approximately 415 local campaigns participated in the 1995 CFC, with federal employee contributions reaching $189 million. Expenses associated with conducting the 1995 CFC totaled $15.6 million.
During this reporting period, we issued one CFC report, a listing of which can be found in Appendix IV on page 35 of this report.

OPM INTERNAL ACTIVITIES AUDITS

Our office also has responsibility for conducting a wide range of audit activity covering OPM programs and administrative operations. This activity includes such diverse areas as financial statement audits required by the Chief Financial Officers Act; President's Council on Integrity and Efficiency government-wide audits; audits of agency compliance with laws and regulations, such as the Prompt Payment Act and the Federal Managers' Financial Integrity Act; and performance audits of OPM programs that involve the range of the agency's responsibilities for retirement, employee development, and personnel management activities.

We have established a one-to-five year optimum audit cycle for each of these audit areas, depending upon the existence of legal requirements to conduct audits and the materiality and other risk factors associated with each activity. However, due to resource limitations, we have eliminated all internal audits from our agenda with the exception of OPM’s financial statements audits. We did not perform any audits of OPM programs and administrative activities this reporting period. However, our Office of Evaluation and Inspections is performing evaluations of agency programs.

A summary of their activities can be found in the Evaluation and Inspections section of this report on pages 27-28.

OPM Financial Statements Audits

OIG staff assigned to OPM internal audits are currently dedicating their time to auditing OPM's salaries and expenses account financial statements, as well as the agency's revolving fund financial statements (an account used to fund OPM business-related functions). Our auditors also are providing oversight of the benefits programs financial statement audits being performed by an independent public accountant.

Audited financial statements for fiscal year 1996 were not produced prior to the end of this reporting period. Reports on audits of these statements will be included in our semiannual report covering the period from April 1, 1997 to September 30, 1997.

Investigative Activities

The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in the federal government's retirement, health and life insurance programs. These trust fund programs cover approximately 9.1 million current and retired federal civilian employees and their family members and disburse over $57 billion annually. The investigation of fraud involving OPM's trust funds occupies the majority of our OIG investigative efforts.

During this reporting period, we have continued to aggressively pursue criminal and civil sanctions against both individuals and corporate entities. These efforts have produced 13 arrests and nine convictions. More importantly, however, they have resulted in judicial and administrative monetary recoveries totaling $19,154,685. Other investigative efforts resulted in the detection of seven ongoing frauds in the Civil Service Retirement System (CSRS), with a projected savings of $232,140 to the Civil Service Retirement and Disability trust fund over the next five years. Overall, we opened 22 investigations and closed 29 during this reporting period, with 118 still in progress at the end of the period. (See Table 1 for investigative activity highlights on page 23 of this section.)

Calls received on our retirement and special investigations hotline and our health care fraud hotline, along with complaints mailed in, totaled 1,564. Additional information, including specific activity breakdowns for each hotline, can be found on page 24-25 in this section.

With respect to the FEHBP trust fund, we have been very successful in monetary recoveries during the reporting period. The result of those efforts is evidenced in out-of-court settlements with two FEHBP carriers that yielded substantial returns to the FEHBP trust fund. Details of those cases can be reviewed in narratives appearing on pages 21-22, respectively.

In the retirement area, we have continued our proactive efforts to identify fraud by routinely reviewing CSRS annuity records for indications of unusual circumstances, as well as maintaining contact with the federal annuitant population. While our recoveries in this area are, for the most part, smaller than in the health care fraud area, criminal prosecutions and sentences tend to be more significant. In addition to the typical fraud scenarios involving individuals who continue to take the annuity payments issued to deceased beneficiaries, cases involving more unique methods of retirement fraud were investigated and closed during this period. One of these cases is highlighted on page 20.

On the following pages, we have provided narratives relating to health care and retirement fund fraud and abuse cases we worked and closed during the reporting period.

Retirement Fraud and Special Investigations

In accordance with our mission to prevent and detect fraud, OIG special agents routinely review CSRS annuity records for indications of unusual circumstances. Using excessive annuitant age as an indication of potential fraud, our investigators attempt to contact the annuitants and determine if they are alive and still receiving their benefits. In addition, we receive inquiries from OPM program offices, other federal agencies and private citizens that prompt us to investigate cases of potential retirement fraud or alleged misconduct by OPM employees and contractors.

Cited below are narratives related to two of the cases in these areas that we completed during this reporting period.

Family Friend Commits Annuity Fraud

As a result of information received from the Georgia Bureau of Investigation (GBI) through the Social Security Administration's OIG, our office notified OPM's Retirement and Insurance Service that a Civil Service Retirement System annuitant had died on
July 31, 1987, but as of August 1995, was still receiving CSRS benefits each month. OPM immediately terminated annuity benefits to the deceased retiree, and a joint investigation by the OIG and GBI was initiated.

This investigation revealed that a family friend of the deceased annuitant, who had been living in the deceased's home for the past 15 years, was the recipient of $37,203 in overpayments. The annuity payments had been directy deposited to a joint bank account held by the deceased annuitant and her surviving sister. The latter, who lives in another state, was interviewed and reported she was unaware that the family friend had been forging her name on personal checks to access the annuity payments and make withdrawals from the account.

The subject of the investigation admitted that he forged the deceased annuitant's name on personal bank checks and on correspondence to OPM for the purpose of accessing the annuity payments and causing the agency to continue sending the payments. After the case was reviewed and declined by the U.S. Attorney's office, the subject was arrested and subsequently pleaded guilty to violations of the Georgia state code concerning theft by taking. He was sentenced to ten years in prison.

Joint Investigative Efforts Result in 10-Year Sentence

OPM Employee Cited for Test Scoring Irregularities

Our office initiated an OPM employee misconduct investigation after the Military Entrance Processing Command's (MEPC) Office of Inspector General notified our office of its belief that an OPM test administrator changed answers on the Armed Services Vocational Aptitude Battery (ASVAB) test. OIG staff at MEPC became

suspicious of the test administrator when they noticed that the test scores of multiple ASVAB test takers rose dramatically, with a corresponding pattern on answer sheets indicating that a significant number of wrong answers had been erased and changed to right answers. They later interviewed the ASVAB test takers, all of whom consistently denied making the changes evidenced on the ASVAB answer sheets. Additionally, the military recruiters denied making any of the changes to the answer sheets. Their statements were supported by the fact that the test applicants in question were handled by different recruiters. One of our OIG special agents and representatives of MEPC's OIG interviewed the OPM test administrator. The test administrator denied changing answers on any test answer sheet. However, she did admit in a sworn affidavit to departing from the written ASVAB test administration procedures in several instances.

Our office subsequently provided a written report of the investigation to the appropriate OPM program office. In February 1997, the OPM test administrator was notified of the final decision to remove her from her position and terminate employment. The test administrator did not contest the personnel action against her.

Employee Misconduct Results in Termination

Health Care-Related Fraud and Abuse

Our OIG special agents are in regular contact with the numerous insurance carriers participating in the FEHBP to provide an effective means for reporting instances of possible fraud by health care providers and FEHBP subscribers. Our office also maintains liaison with federal law enforcement agencies involved in health care fraud investigations and participates in several health care fraud working groups on both national and local levels. Additionally, we work closely with our own Office of Audits when fraud issues arise during the course of health carrier audits.

The following narratives describe four of the cases we concluded in the area of health care fraud during this reporting period.

Health Carrier Overcharges Result in Monetary Settlement

As a result of information received from our Office of Audits, we initiated an investigation of FHP, Inc., based in Fountain Valley, California, to determine if it overcharged the FEHBP for health insurance premiums during contract years 1987 through 1991. The investigation determined that FHP gave discounts to private employer groups by using unsupported demographic assumptions when calculating their premiums. No such discounts were given to the FEHBP, even though FHP, Inc., was required to charge the FEHBP prices equivalent to those charged to the private sector.

The case was presented to the U.S. Attorney's office, which resulted in FHP, Inc., agreeing to an out-of-court settlement with the government in the amount of $12 million. The payment received by the FEHBP trust fund from this settlement will be used to reduce future premiums paid by FHP, Inc. enrollees and the federal government. For more information regarding our audit of this health plan, see pages 9-10 of this report.

Health Carrier Inflates Administrative Expenses

In another health carrier case, OIG special agents, in conjunction with our Office of Audits, investigated Blue Cross and Blue Shield of Utah for overstating its administrative expenses during contract years 1987 through 1990. BCBS of Utah is headquartered in Salt Lake City.

Our investigation determined that for each of these contract years, BCBS of Utah made year-end manual adjustments to its accounting system, which increased the number of employee work hours billed to OPM. The changes were not consistent with time sheets completed by the health plan's employees.

After the case was presented for judicial action, BCBS of Utah agreed to an out-of-court settlement of $2.2 million. As as a result of the agreement, $1,665,000 was returned to the FEHBP trust fund and $535,000, representing damages, was returned to the U.S. Treasury. The money returned to the trust fund will be used to reduce future premiums paid by the plan's enrollees and the government. Additional information on our audit of this health plan can be found on pages 11-13 of this report.

Health Carriers Reimburse U.S. Government $14.2 Million

Federal Agencies Share in Clinical Laboratory Settlement

In 1993, at the request of the U.S. Attorney's office, OPM entered into a national health care fraud initiative targeting clinical laboratories in the United States. The laboratories were suspected of billing for tests not ordered by individual physicians or misleading physicans into believing that certain tests were part of a package and then billing health carriers separately for those tests.

As a result of this initiative, SmithKline Beecham Clinical Laboratories, one of our nation's largest laboratories, headquartered in Philadelphia, Pennsylvania, entered into a settlement with the Department of Justice and agreed to pay the federal government $325 million. The $325 million payment is being shared by several participating federal agencies, including the Department of Health and Human Services (HHS), the U.S. Railroad Retirement Board, the Office of the Civilian Health and Medical Program of the Uniformed Services and OPM. Our agency incurred actual damages of $1,632,296 and will receive full reimbursement for that amount, as well as $351,000 for lost interest income. An additional $1,632,296 will

be credited to the U.S. Treasury on OPM's behalf for damages.

Questioned Laboratory Billings Result in Return of FEHBP Funds

Another clinical laboratory-related case that concluded during this reporting period concerned Damon Clinical Laboratories, a national laboratory chain headquartered in Massachusetts. As part of an HHS/DOJ initiative, the U.S. Attorney's office in Massachusetts coordinated an investigation of this health care provider, which was suspected of submitting claims for lab tests that were either not medically necessary or not requested by a physician.

In this particular case, the U.S. Attorney's office requested that our office obtain pertinent claims billing information pertaining to this laboratory for the years 1989 through 1993. Our investigators were able to determine that Damon used highly questionable billing practices to get FEHBP fee-for-service carriers to pay the company $95,726 for its testing services for the years in question. In a settlement agreement with the federal government, Damon agreed to pay $80,915,900, of which $287,178 was returned to the FEHBP trust fund.

OPM Awarded $3.9 Million in Provider Settlements

Sentencing Update

As referenced in our last semiannual report, our office initiated an investigation of an employee of the National Association of Letter Carriers Health Plan, who was suspected of submitting fraudulent health insurance claims.

The employee, a supervisory claims examiner, was interviewed and admitted receiving $82,791 as a result of false claims he had submitted between 1992 and 1996. On December 6, 1996, the employee was sentenced in U.S. District Court in Alexandria, Virginia, to one year in prison, three years of probation and ordered to pay a $6,000 fine.

TABLE 1: Investigative Highlights

Judicial Actions:

Arrests	13
Indictments	11
Convictions	9

Administrative Actions:[1] 1

Judicial Recoveries:

Fines, Penalties, Restitutions and Settlements[2]	$18,998,686

Administrative Recoveries:

Settlements and Restitutions	$155,999

Total Funds Recovered $19,154,685

[1]*Includes suspensions, reprimands, demotions, resignations, removals, and reassignments.*

[2]*$13,118,960 of this amount was the result of the joint efforts of our OIG investigators and auditors. See also "Questioned Costs" in Appendix I, page 30, of this report..*

OIG Hotlines

The OIG maintains two hotlines, the Retirement and Special Investigations hotline and the Health Care Fraud hotline.

Retirement and Special Investigations Hotline

The Retirement and Special Investigations hotline provides the same assistance as traditional OIG hotlines. For example, we receive inquiries from OPM employees, contractors, and others interested in reporting waste, fraud and abuse within the agency. Callers, or those who choose to write letters, can report information openly, anonymously or confidentially without fear of reprisal.

The Retirement and Special Investigations hotline and complaint activity for this reporting period included 69 telephone calls, 59 letters, 54 agency referrals, and 189 complaints initiated by the OIG, for a total of 371. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled $129,786.

OIG-initiated complaints: Complaints initiated by our office can be one of two types. The first occurs when the agency has already received information indicating an overpayment to an annuitant has been made, and our review leads us to determine there are sufficient grounds to justify our involvement due to the potential for fraud. There were 11 such complaints associated with agency inquiries during this reporting period.

The second type of OIG-initiated complaint occurs when we review the agency's automated annuity records system for certain items that may indicate a potential for fraud. At that point, we initiate personal contact with the annuitant to determine if further investigation is warranted. This proactive activity resulted in 178 instances where our office initiated personal contacts to verify the status of the annuitant.

Health Care Fraud Hotline

The Health Care Fraud hotline was established to handle complaints from subscribers in the Federal Employees Health Benefits Program administered by OPM. The hotline number is listed in the brochures for all the plans associated with the FEHBP.

While the hotline is designed to provide an avenue to report fraud by subscribers, health care providers or FEHBP carriers, frequently callers have requested assistance with disputed claims and services disallowed by the carriers. Each caller receives a follow-up call or letter from either the OIG hotline coordinator, the insurance carrier

or another OPM office as appropriate.

The Health Care Fraud hotline and complaint activity for the period involved 997 telephone calls and 196 letters, for a total of 1193. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled $26,213.

TABLE 2: Hotline Calls and Complaint Activity

Retirement and Special Investigations Hotline and Complaint Activity:

Retained for Investigation	285
Referred to:	
OIG Office of Audits	0
OPM Groups and Offices	39
Other Federal Agencies	47
Total	**371**

Health Care Fraud Hotline and Complaint Activity:

Retained for Investigation	190
Referred to:	
OPM Groups and Offices	415
Other Federal/State Agencies	178
Health Insurance Carriers or Providers	410
Total	**1193**

Total Contacts 1564

Evaluation and Inspections Activities

Section 4 (a)(3) of the IG Act directs IGs to conduct activities to promote economy and efficiency. We have defined evaluation and inspections as a core function of our office. Through this function, we are providing assistance to agency program managers in their efforts to determine the feasibility of new initiatives and the effectiveness and efficiency of existing operational methodologies. We conduct independent analytical reviews that often serve as the cornerstone for strategies to improve the delivery of services throughout the agency.

This office provides the agency with a unique tool to address some of the pressing problems associated with today's government reorganizing. The evaluative process used by this office, whether requested or mandated, focuses on current issues, such as reduced funding, increased workloads, decreasing staffing levels, inefficient or ineffective services, customer or public questions concerning delivery of services, and the lack of objective evaluative data to use in determining the impact of programs.

OPM has been on the forefront of the Administration's efforts to improve the quality of services and reduce the size of government. The agency's program offices have experienced reorganizations, staff reductions, and new program mandates during the last few years, with the intended objective of becoming a "model agency" for the twenty-first century. Questions have been raised both within the agency and from other interested parties concerning how OPM will be able to meet these challenges. We are now working with agency offices to conduct evaluations of existing services that will formulate strategies to improve services, increase accountability and minimize resource demands.

As previewed in our last semiannual report, our staff has commenced reviews of two common service administrative offices in OPM. Of concern is whether reduced funding and the resulting reductions in staff within these offices have had a dramatic impact on their servicing abilities. These evaluations will determine if the administrative offices can provide a level of service necessary to support the redefined core functions of the agency. While the services provided by administrative functions do not have a high level of visibility outside the agency, nevertheless, the ability of program offices to achieve the agency's primary objectives are closely associated with these operations.

We completed one of these reviews, an evaluation of the delivery of information technology services in OPM, during the current reporting period. A summary of that evaluation follows.

OPM Information Technology Service Delivery

During fiscal year 1995, the Office of Personnel Management announced various changes in its organizational structure that altered agency requirements for administrative services. This study was initiated primarily to determine if the resulting reductions in staff and funding for the Office of Information Technology (OIT) adversely affected the ability of that organization to provide the information technology services required by OPM customer organizations.

The study team found that, in spite of a nearly 51 percent reduction in staff, OIT has done a commendable job of maintaining levels of service that are near the levels available before the common services reductions-in-force took place at the end of fiscal year 1995. Service has been maintained in part through additional use of contractors for some tasks that were previously handled in-house. However, it appears that in some areas of OIT, staff has been extended to the breaking point with overtime and deferred leave. This led us to conclude that it does not appear that services can be maintained at the same levels indefinitely with current staffing.

We included in our recommendations that there be organizational and staffing adjustments to realign disparate information technology functions. We also recommended placing the Washington Data Processing Center, which serves the entire agency, into the OIT organization. In addition to increasing the level of backup and expertise available for some isolated functions, such realignment would provide more efficient central control over enterprise-wide data processing operations.

Index of Reporting Requirements (Inspector General Act of 1978, As Amended)

APPENDIX I
Final Reports Issued With Questioned Costs
October 1, 1996 to March 31, 1997

		Number of Reports	Questioned Costs	Unsupported Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	14	$ 34,485,949	$ 391,881
B.	Reports issued during the reporting period with findings	13	49,455,069[1]	0
	Subtotals (A+B)	27	83,941,018	391,881
C.	Reports for which a management decision was made during the reporting period:	16	54,747,829	391,881
	1 Disallowed costs		43,705,891	150,000
	2 Costs not disallowed		11,041,938	241,881
D.	Reports for which no management decision has been made by the end of the reporting period	11	29,193,189	0
	Reports for which no management decision has been made within 6 months of issuance	1	2,326,131[2]	0

[1] *This amount includes $13.1 million, which was the subject of joint efforts by our Office of Audits and Office of Investigations and the Civil Division of the U.S. Attorney's office for the District of Columbia. This amount is also reflected in Table I, Investigative Highlights, on page 23 of this report.*

[2] *Resolution of this item has been postponed at the request of the OIG.*

APPENDIX II
Final Reports Issued With Recommendations
For Better Use of Funds
October 1, 1996 to March 31, 1997

		Number of Reports	Dollar Value
A.	Reports for which no management decision had been made by the beginning of the reporting period	0	$ 0
B.	Reports which were issued during the reporting period	1	85,800
	Subtotals (A+B)	1	85,800
C.	Reports for which a management decision was made during the reporting period:	1	85,800
	1. Dollar value of recommendations that were agreed to by management		0
	2. Dollar value of recommendations that were not agreed to by management		85,800
D.	Reports for which no management decision has been made by the end of the reporting period	0	0
	Reports for which no management decision has been made within 6 months of issuance	0	0

APPENDIX III
Insurance Audit Reports Issued
October 1, 1996 to March 31, 1997

Subject *(Standard Audits)*	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Group Health Northwest in Spokane, Washington	VR-00-95-001	October 7, 1996	$ 989,760	$ 0
Blue Cross and Blue Shield of Georgia in Atlanta, Georgia	10-05-93-008	November 13, 1996	1,305,859	
Blue Cross and Blue Shield of Indiana in Indianapolis, Indiana	10-39-93-012	November 18, 1996	4,304,541	
Blue Cross and Blue Shield of Mississippi in Jackson, Mississippi	10-40-96-003	November 22, 1996	533,305	
Humana Health Plan of San Antonio, Texas	TZ-00-93-047	December 18, 1996	2,494,048	
Foundation Health of Rancho Cordova, California	C6-00-95-015	January 15, 1997	2,701,316	
Union Labor Life Insurance Company as Underwriter/Administrator for the National Association of Government Employees Health Benefit Plan, Washington, D.C.	YJ-04-94-041	January 16, 1997	843,225	
Blue Cross and Blue Shield of Texas in Dallas, Texas	10-29-94-043	January 22, 1997	7,017,223	
Share Health Plan of Illinois, Inc., in Itasca, Illinois	FP-00-94-022	January 30, 1997	7,722,087	
CIGNA Healthplan of Tennessee, Inc., in Nashville, Tennessee	SZ-00-93-033	January 30, 1997	439,731	

APPENDIX III
Insurance Audit Reports Issued
October 1, 1996 to March 31, 1997

Subject (*Standard Audits*)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Blue Cross and Blue Shield of Utah in Salt Lake City, Utah[1]	10-66-91-028	January 29, 1997	$ 1,578,669	$ 0
Union Labor Life Insurance Company as Underwriter/Administrator for the American Federation of Government Employees Health Benefit Plan	30-04-94-040	February 14, 1997	1,771,712	
FHP, Inc., in Fountain Valley, California[2]	66-00-92-059	March 12, 1997	17,753,593	
TOTALS			**$ 49,455,069**	**$ 0**

[1]*This audit was referred within OIG to our Office of Investigations. The Civil Division of the U.S. Attorney's office for the District of Columbia resolved this report in the amount of $2,200,000, of which $535,000 was designated as funds to be returned to general treasury. Also $1.1 million is reflected in Table 1, Investigative Highlight, page 24.*

[2]*This audit was referred within OIG to our Office of Investigations. The Civil Division of the U.S. Attorney's office for the District of Columbia resolved this report in the amount of $12,000,000, which is reflected in Table 1, Investigative Highlights, page 26.*

Appendix IV
Combined Federal Campaign
and
Other External Audit Reports Issued
October 1,1996 to March 31, 1997

Subject	Report Number	Issue Date	Funds Put to Better Use	Questioned Costs
Hilton Consulting Corporation's Cost Proposal	99-FF-96-402	November 14, 1996	$ 85,800	$ 0
The 1992, 1993, 1994 and 1995 Combined Federal Campaigns of South Hampton Roads, Norfolk, Virginia	2A-CF-96-200	November 25, 1996		
TOTALS			**$ 85,800**	**$ 0**